

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 1 — 0 0 4

2. STATE:

GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

~~XXXXXX~~ March 29, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.321

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 23,390,259

b. FFY 2002 \$ 31,187,012

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

ATTACHMENT 4.19-B, pp. 8a.3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

ATTACHMENT 4.19-B, pp. 8a.3

10. SUBJECT OF AMENDMENT:

OUTPATIENT HOSPITAL - UPPER PAYMENT LIMIT RATE ADJUSTMENTS

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ OTHER, AS SPECIFIED:☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Mark Trail

14. TITLE:

Acting Director, Division of Medical Assistance

15. DATE SUBMITTED:

16. RETURN TO:

Georgia Community Health  
Division of Medical Assistance  
2 Peachtree Street, N.W.  
Atlanta, Georgia 30303-3159

17. DATE RECEIVED:

March 29, 2001

18. DATE APPROVED:

December 20, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

March 29, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Eugene A. Grasser

22. TITLE: Associate Regional Administrator  
Division of Medical and State Operations

23. REMARKS:

---

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES  
FOR OTHER TYPES OF CARE OR SERVICES

---

For payments made for services provided on or after March 29, 2001, subject to the availability of funds in the year in which the interim and final rate is paid, State government-owned or operated facilities, non-State government owned or operated facilities and Critical Access eligible hospitals which meet departmental requirements will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that, based on their status as government owned or operated, need sufficient funds for their commitments to meet the healthcare needs of all members of their communities. A facility's status as government owned or operated will be based on its ability to make direct or indirect intergovernmental transfer payments to the State. If sufficient funds are not available to provide maximum allowable payment amounts, rate adjustment payments may be reduced proportionally among facilities eligible to receive payment.

The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State government-owned or operated facilities, non-State government owned or operated facilities and all other facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:

- Amounts paid for services provided to Medicaid patients and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost based or rate payment measures may be used as Medicare payment principles.

Comparisons of amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determine facility-specific rate adjustment payments. If an individual facility cannot be paid a portion of its full rate adjustment payment due to a facility-specific charge limit, this rate adjustment amount can be allocated to other facilities that are eligible to receive additional rate adjustment payments without exceeding facility-specific charge limits. These rate payment adjustments will be made on a monthly, quarterly or annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

An example of how a rate adjustment payment could be calculated is presented on the following page.

---

---

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES  
FOR OTHER TYPES OF CARE OR SERVICES

Facility Name	XYZ Hospital
1 Most recent audited cost report period end date	06/30/1998
2 Medicaid Outpatient Costs	391,364
3 Medicaid Outpatient Charges	623,841
4 Medicaid Outpatient Cost to Charge Ratio	62.73%
5 Adjustment factor for inflation from cost report end date to CY2001	1.1091
6 Covered charges for services subject to cost settlement adjusted for inflation	614,027
7 Cost of services subject to cost settlement adjusted for inflation (line 4 x line 6)	385,179
8 Payments for service subject to cost settlement if paid at lower of 90% of cost or charges	346,661
9 Payments for service subject to cost settlement if paid at lower of 100% of cost or charges	0
10 Covered charges for services not subject to cost settlement adjusted for inflation	328,620
11 Cost of services subject to cost settlement adjusted for inflation (line 4 x line 10)	206,143
12 Payments for services not subject to cost settlement adjusted for inflation	61,574
13 Total charges for services adjusted for inflation	974,172
14 Cost of all services adjusted for inflation (line 7 + line 11)	591,322
15 Payments for all services adjusted for inflation (line 8 + line 9 + line 12)	408,235
16 Facility-specific limit at 150% of cost (line 14 x 150%)	886,983
17 Lower of total charges or 150% of cost (< of line 13 or line 16)	886,983
18 Maximum facility-specific annual upper payment limit rate adjustment (line 17 - line 15)	478,748

---

TN No. 01-004  
Supersedes  
TN No. New

Approval Date DEC 20 2001

Effective Date MAR 29 2001